Essex Pediatrics
89 Main Street
Essex Junction, VT
(802) 879-6556 Phone
(802) 872-8021 Fax

_____
(Patient Name)

_____
(DOB)

(Form D Revised 2/01/17)

Authorization to Disclose Medical Information

By signing this permission form, you authorize Essex Pediatrics to release information to or receive information from the parties listed below.

I authorize Essex Pediatrics to (please only check one per authorization):

□ Send information to: □ Receive information from:

_____
(Name)

_____
(Address: City, State, Zip Code)

_____ _____
(Phone) (Fax)

For the following purpose(s)

□ Continuation of Treatment □ Provider Transfer □ Insurance □ Worker's Compensation
□ Attorney □ Personal Records □ Disability □ Other

Medical records to be sent:

☐ Clinical summary **(includes records from the past five years)**

OR **(indicate below and include dates as necessary)**

☐ Office Notes ☐ Problem Lists ☐ Hospital Admissions
☐ Medication Lists ☐ Immunizations ☐ Emergency Room Reports
☐ Laboratory/Radiology Reports ☐ Specialty Reports ☐ Other _____

Special Medical Records:

The following medical records have special protections. We need your specific permission to send the records listed below **(initial all that apply)**:

☐ Mental health records _____ *(initial)*
☐ HIV/AIDS records _____ *(initial)*
☐ Alcohol/drug treatment records _____ *(initial)*
☐ Sexual abuse/assault and domestic violence records _____ *(initial)*
☐ Sexually-transmitted disease records _____ *(initial)*

Records to be:

☐ Mailed ☐ Faxed ☐ Collected by patient or legally authorized representative

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(Patient Name)

_____
(DOB)

I understand that:

- The recipient authorized to receive my information may not be required to protect my information and may share my records without my permission.
- Signing this form is voluntary. I do not need to sign this form to receive health care services at Essex Pediatrics.
- I may cancel this authorization at any time by providing **written notice** to Privacy Officers, Sue Rogers-Low or Jill Kenneson at 89 Main St, Essex Junction, Vermont, 05452. My revocation will not apply to the information that has already been released in response to this authorization.
- I may inspect or copy any information to be used or disclosed under this authorization.
- I may be charged a fee for copies of my records. The usual charge is either a flat fee of $5.00 or $0.50 per page-whichever costs more.
- Unless otherwise cancelled in writing, this authorization will automatically **expire one year** from the date I sign below.

Signature: _____ Date: _____ Time: _____
(Patient/legal representative)

_____
(City, State, Zip Code)

_____ _____
(Phone) (Fax)

If signing for a minor:

Legally Authorized Representative's Name: _____
(Print)

Legal Authority (check one):

__ Parent of Minor __ Legal Guardian __Other

For Office Use Only

Date request filed: _____
(Date and initial)

Date request completed: _____
(Date and initial)

☐ Handed to parent/patient ☐ Placed in pick-up file for collection

☐ Mailed to requested address ☐ Faxed to requested number